No. 300
10.48

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42114

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11129

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 1
c. CITY OR TOWN: St. Louis 12 2129
d. STREET ADDRESS (If rural, give location): 789 Aubert 6

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) c. (Last) Cooper

4. DATE OF DEATH: (Month) Dec. (Day) 22 (Year) 1950

5. SEX: Male 2

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 4/3/1916

9. AGE (In years last birthday): 34 If under 1 year: Months 8 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none - invalid

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): St. Louis, Missouri 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Malachi Cooper

13b. MOTHER'S MAIDEN NAME: Delia Cowan

14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Delia Cooper, 789 Aubert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Multiple Sclerosis and Multiple — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Decubitus Ulcer
DUE TO (c): Undetermined

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 345A

22. *I hereby certify that I attended the deceased from* 11-22, 19 50, *to* 12-22, 19 50 *that I last saw the deceased alive on* 12-22, 19 50, *and that death occurred at* 2:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. D. Lawrence M. D.

23b. ADDRESS: 2601 N Whittier St

23c. DATE SIGNED: 12-26-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/28/50

24c. NAME OF CEMETERY OR CREMATORY: Washington Park

24d. LOCATION (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG.: DEC 27 1950

REGISTRAR'S SIGNATURE: A B Lasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: GATES FUNERAL HOME Charles J. Gates, 4107 Finney Avenu

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

_____,

working under my personal supervision.

Student Embalmer No.....

Signed John K Cunningham

Signed.....
Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.